

# CaAIM Enhanced Care Management & Community Supports Office Hours

Long-Term Care ECM Populations of Focus  
and

Community Supports for SNF Transition/Diversion to ALFs & Community  
Transition Services/SNF Transition to a Home



*September 22, 2022*

# Public Health Emergency (PHE) Unwinding

- » **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- » **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- » **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the [DHCS Coverage Ambassador webpage](#)
  - [Join the DHCS Coverage Ambassador mailing list](#) to receive updated toolkits as they become available

# DHCS PHE Unwind Communications Strategy

- » **Phase One: Encourage Beneficiaries to Update Contact Information**
  - Launch immediately
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
  - Flyers in provider/clinic offices, social media, call scripts, website banners
  
- » **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

# ECM and Community Supports Data Guidance Survey

DHCS is requesting that all MCPs and launched ECM and Community Supports Providers complete [this survey](#) on ECM and Community Supports data transactions, and where persistent data exchange barriers may benefit from expanded or refined data guidance. DUE OCTOBER 7<sup>th</sup>

- » Before the launch of ECM and Community Supports, **DHCS developed guidance to standardize information exchange, increase efficiency and reduce administrative burden between the state, MCPs and ECM and Community Supports Providers** (e.g., [ECM Member Information File](#), [ECM/Community Supports Billing and Invoicing Guidance](#), [NPI application instructions](#)).
- » The survey is an opportunity for stakeholders to **provide feedback on early implementation and crucial input for DHCS** to ensure the long-term adoption and success of the ECM benefit and Community Supports.

## [ECM and Community Supports Data Guidance Survey](#)

**The survey must be completed by all MCPs and their contracted ECM and Community Supports providers by OCTOBER 7<sup>th</sup>.**

Please reach out to the [CalAIM ECM and Community Supports Mailbox](#) with any questions.

More information can be found at [www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices](http://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices).

# Welcome to Office Hours

**“Office Hours”** are a Q&A discussion with DHCS leaders and stakeholders implementing CalAIM focused on a specific implementation topic.

## *Today's Topic: Long-Term Care*

- » **Introductions**
- » **How to Ask Questions**
- » **Q&A Discussion**
  - » **ECM for New Long-Term Care Populations of Focus**
  - » **Nursing Facility Transition/Diversion to Assisted Living Facilities**
  - » **Community Transition Services/Nursing Facility Transition to Home**

# Today's Panelists

## DHCS

**Joseph Billingsley**

Long-Term Services and Supports Operations Branch

**Aita Romain**

Quality and Population Health Management Division

**Dana Durham**

**Michel Huizar**

**Michelle Wong**

Managed Care Quality and Monitoring Division

## Featured Panelists

**Ed Mariscal**, Director of Public Programs and Long-Term Services & Supports, Health Net

**Anwar Zoueihid**, Vice President of Long-Term Services & Supports, Partners in Care Foundation

**Jorge Medina**, Director of Business Development, Serene Health

**Jeannine Nash**, Director of Operations, Serene Health

**Nicole Bell**, Community Supports Program Manager, Santa Clara Family Health Plan

# Today's Questions

Questions from today's session were sourced from previous webinar Q&A and questions submitted via email or the sessions' registration page.



## Use the meeting chat

- » Ask questions
- » Share your own experiences



## Get in line to ask a question

- » Use "Raise Hand" in Zoom to get in the line to ask a question
- » Facilitators will call on people in the line and take them off mute so they can ask a question

# Today's Questions

## *Raising Your Hand to Ask a Question*



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# Topics for Today's Office Hours

## Enhanced Care Management

ECM for Adults Living in the Community Who Are At Risk for LTC Institutionalization

ECM for Nursing Facility Residents Transitioning to the Community

## Community Supports

Nursing Facility Transition/Diversion to Assisted Living Facilities

Community Transition Services/Nursing Facility Transition to a Home

# Understanding CalAIM, ECM, and Community Supports

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# California Advancing and Innovating Medi-Cal (CalAIM)

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CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The goals of CalAIM include:



Implementing a whole-person care approach and address social drivers of health.



Improving quality outcomes, reduce health disparities, and drive delivery system transformation.



Creating a consistent, efficient and seamless Medi-Cal system.

# Key CalAIM Components in 2022: Enhanced Care Management (ECM) and Community Supports

On January 1, 2022, DHCS launched the first components of CalAIM:  
Enhanced Care Management and Community Supports.

## Enhanced Care Management (ECM)

A **Medi-Cal managed care benefit** that will address clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management

## Community Supports

Services that **Medi-Cal managed care plans are strongly encouraged, but not required, to provide** as medically appropriate and cost-effective alternatives to utilization of other services or settings such as hospital or skilled nursing facility admissions

# What is ECM?

**ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).**

- » ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home
- » ECM is part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on member need, with ECM as the highest intensity level

## Seven ECM Core Services



**Outreach and Engagement**



**Member and Family Supports**



**Comprehensive Assessment and Care Management Plan**



**Health Promotion**



**Enhanced Coordination of Care**

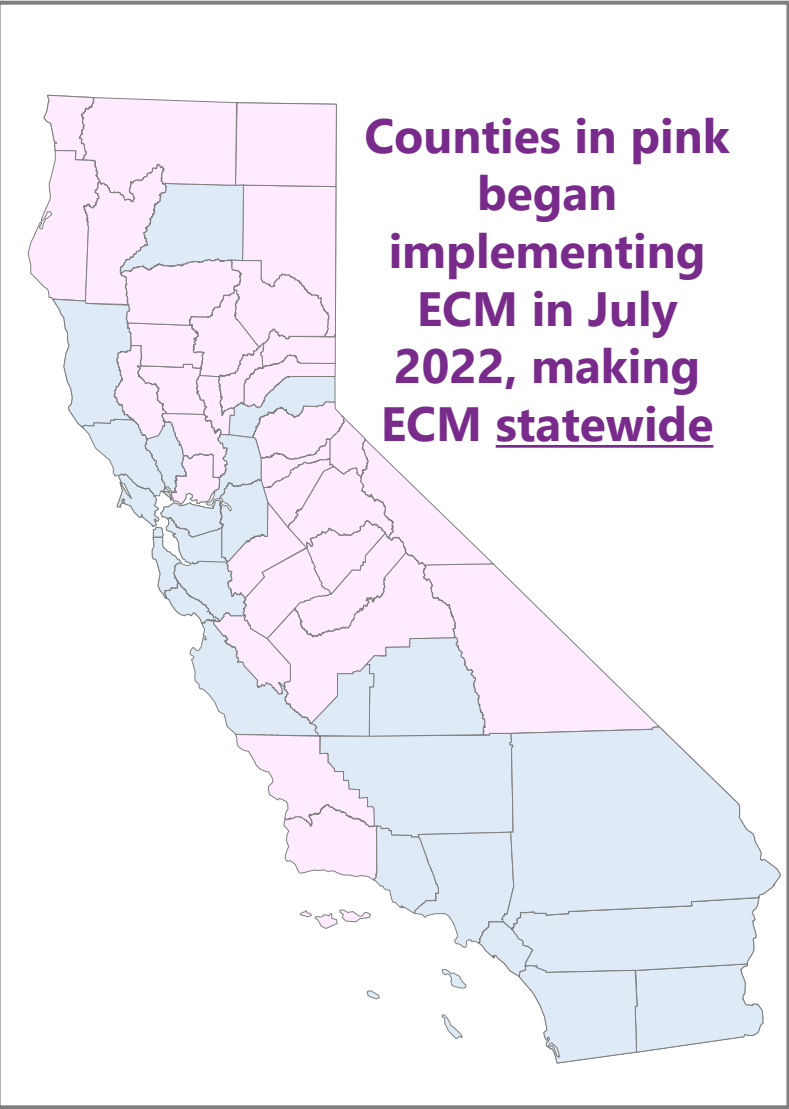


**Comprehensive Transitional Care**



**Coordination of and Referral to Community and Social Support Services**

# Launch and Expansion of ECM



ECM Populations of Focus	Go-Live Timing
<ul style="list-style-type: none"> <li>• Individuals and Families Experiencing Homelessness</li> <li>• Adult At Risk of Avoidable Hospital/ED Utilization</li> <li>• Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)</li> <li>• Transitioning from Incarceration (some WPC counties)</li> </ul>	<p><b>January 2022</b> (WPC / HH counties)  <b>July 2022</b> (all other counties)</p>
<ul style="list-style-type: none"> <li>• At Risk for Institutionalization and Eligible for Long Term Care</li> <li>• Nursing Facility Residents Transitioning to the Community</li> </ul>	<p><b>January 2023</b></p>
<ul style="list-style-type: none"> <li>• Children / Youth Populations of Focus</li> <li>• Transitioning from Incarceration (statewide)</li> </ul>	<p><b>July 2023</b></p>

# What are Community Supports?

**Community Supports are services that Medi-Cal managed care plans (MCPs) are strongly encouraged but not required to provide as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.**

- » Community Supports are designed as cost-effective alternatives to traditional medical services or settings and to address social drivers of health (factors in people's lives that influence their health)
- » Different MCPs offer different combinations of Community Supports
- » MCPs must follow the DHCS standard Community Supports service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate
- » Community Supports are not restricted to ECM Populations of Focus and should be made available to all Members who meet the eligibility criteria for a specific Community Support

# What are Community Supports?

## Pre-Approved DHCS Community Supports

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Meals/Medically-Tailored Meals or Medically-Supportive Foods
13. Sobering Centers
14. Asthma Remediation

For more details, see [Community Supports Policy Guide](#) (August 2022).



# Community Supports for Members in Long-Term Care Populations of Focus

**The entire menu of Community Supports may be applicable to Members in the Long-Term Care Population of Focus, but each Member will have different needs and functional limitations.**

Community Supports that may benefit members in the Long-Term Care Populations of Focus include, but are not limited to:

- » Nursing Facility Transition/Diversion to Assisted Living Facilities
- » Community Transition Services/Nursing Facility Transition to a Home
- » Environmental Accessibility Adaptations (Home Modifications)
- » Respite Services
- » Personal Care and Homemaker Services

*For more details, see [Community Supports Policy Guide](#) (August 2022).*

# Coming to CalAIM in 2023

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# CalAIM Components that Go-Live in 2023 that Impact Dual Eligible Members / Seniors & Persons with Disabilities (SPDs)

Cal MediConnect (CMC) ends and **Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans)**, formerly known as Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs), will be launched in the Coordinated Care Initiative (CCI) counties.

**Long Term Care (LTC) carve-in** in remaining Two-Plan, Geographic Managed Care (GMC) and Regional Model Counties

Statewide **mandatory Medi-Cal managed care enrollment** for dual eligible members

**Population Health Management (PHM) Program** go-live in the Medi-Cal Managed Care Delivery System

**Enhanced Care Management Long-Term Care (LTC) Populations of Focus** launch

# Two New Long-Term Care Populations of Focus for ECM

On January 1, 2023, two new Populations of Focus will launch for Enhanced Care Management:

**Adults Living in the Community  
Who Are At Risk for LTC  
Institutionalization**

**Nursing Facility Residents  
Transitioning to the Community**

# Adults Living in the Community Who Are At Risk for LTC Institutionalization

## *Population of Focus Definition*

### Definition

(1) Adults living in the community who meet the Skilled Nursing Facility (SNF) Level of Care criteria;<sup>1</sup> **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;<sup>2</sup>

### **AND**

(2) are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring),<sup>3</sup>

### **AND**

(3) are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

For more details, see [ECM Policy Guide](#) (May 2022).

# Adults Living in the Community Who Are At Risk for LTC Institutionalization

## *Population of Focus Definition - Continued*

### **Notes on the Definition:**

- » **Living in the Community:** Members who meet this Population of Focus may live in independent housing, Residential Care Facilities, Residential Care Facilities for the Elderly (RCFEs), or any other dwelling that meets the requirements established in the Home and Community Based Services (HCBS) Settings Final Rule.<sup>4</sup>
- » **Exclusions:** Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF) and subacute care facilities are excluded from this Population of Focus.

1. As established in the [California Code of Regulations 51335](#)
2. Criteria adapted from the [2020 Medi-Cal Long-Term Care At Home proposal](#)
3. Criteria adapted from the [Community-Based Health Home eligibility criteria](#)
4. CMS Final Rule 79 FR 2947, Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; 42 CFR 441.301(c)(4) and (5)

For more details, see [ECM Policy Guide](#) (May 2022).

# Nursing Facility Residents Transitioning to the Community

## *Population of Focus Definition*

### Definition

Nursing facility residents who are:

- » Interested in moving out of the institution;
- » Are likely candidates to do so successfully; and
- » Able to reside continuously in the community.

### ***Notes on the definition:***

- » **Able to Reside Continuously in the Community:** Members transitioning to the community may need to return to the hospital or SNF intermittently for short admissions (potentially due to changes in medical conditions or other acute episodes). They should not be precluded from being considered able to reside continuously in the community.
- » **Exclusions:** Individuals residing in Intermediate Care Facilities (ICF) and subacute care facilities are excluded from this Population of Focus.

For more details, see [ECM Policy Guide](#) (May 2022).

# Q&A



# Topics for Today's Office Hours

## Enhanced Care Management

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# Thank You!

## Upcoming Webinars

### **ECM and Community Supports in Rural CA Office Hours**

Thursday, September 29th  
2:00 – 3:00 PM PT

[Registration link](#)

### **Housing Supports via ECM & Community Supports Webinar**

Thursday, October 13th  
1:30 – 3:00 PM PT

[Registration link](#)

### **Community Supports Spotlight: Housing Supports**

Thursday, October 20th  
1:30 – 3:00 PM PT

*Registration link coming soon*

### **Housing Supports via ECM & Community Supports Office Hours**

Thursday, October 27th  
2:00 – 3:00 PM PT

[Registration link](#)

### **ECM and Community Supports Data Sharing Webinar**

Thursday, November 10th  
1:30 – 3:00 PM PT

[Registration link](#)

### **ECM and Community Supports Office Hours for New Counties**

Thursday, November 17th  
2:00 – 3:00 PM PT

[Registration link](#)

# Additional Resources

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# Review DHCS Resources & Materials for Providers

- » Learn more about ECM & Community Supports:
  - [Policy Guide](#)
  - [FAQs](#)
  - Fact Sheets: [ECM](#) & [Community Supports](#)
  - [ECM Key Design Implementation Decisions](#)
  - [Community Supports MOC Template](#)
  - [ECM MOC Template](#)
- » Review ECM & Community Supports guidance documents:
  - [Billing & Invoicing Guide](#)
  - [Coding Options](#)
  - [Community Supports Pricing Guide \(Non-Binding\)](#)
  - [Data Guidance for Member-Level Information Sharing](#)
  - [Contract Template Provisions](#)
  - [Standard Provider Terms & Conditions](#)



# ECM Eligibility for Dual-Eligible Members

## *Overview for 2022*

Figure 2: Overview of ECM Eligibility for Dual-Eligible Members in 2022

Medicaid & Medicare Delivery Model or Other Programs	ECM Eligible
Cal MediConnect	No
FIDE-SNPs	No
PACE Programs	No
Medi-Cal MCP + Medicare FFS	Yes
Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + D-SNP Look-alike	Yes
Medi-Cal MCP + D-SNP	Yes
Medi-Cal FFS + Medicare FFS or Plan <i>(not MCP enrolled)</i>	No
Any other excluded program (e.g., 1915(c), CCT)	No



# ECM Eligibility for Dual-Eligible Members

## Overview for 2023 and Beyond

Figure 3: Overview of ECM Eligibility for Dual-Eligible Members in 2023 and Beyond

Medicaid & Medicare Delivery Model	ECM Eligible
Medi-Cal MCP + <u>EAE</u> D-SNPs	No
FIDE-SNPs	No
PACE Programs	No
Medi-Cal MCP + Medicare FFS	Yes
Medi-Cal MCP + Other MA	Yes
Medi-Cal MCP + <u>non EAE</u> D-SNP	Yes in 2023; No from 2024
Medi-Cal FFS + Medicare FFS or Plan (not MCP enrolled)	No
Any other excluded program (e.g., 1915(c), CCT)	No

# ECM: Adults Living in the Community Who Are At Risk for LTC Institutionalization

## Summarized Operational Guidance

### Identification

- » **Referrals** will be the predominant pathway MCPs use to identify eligible Members
- » MCPs may also leverage existing **Member data**, data sharing with contracted Providers, 1915 (c) HCBS waiver program wait lists, previous SNF Level of Care determinations to identify members

### Assessment and Care Plan

- » **Assessment:** For Members who may have LTSS needs, MCPs must continue to include DHCS' standardized Long-Term Services and Supports (LTSS) referral questions<sup>1</sup> as part of the assessment
- » **Care Plans:** If the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, should reflect Member preferences, and should incorporate LTSS and all wraparound services and supports that will ensure the Member is setup to live continuously in the community

### Provider Contracting

- » MCPs are required to contract with **providers who have experience** serving Members who meet this POF, which may include CBAS Centers, Area Agencies on Aging, Home Health Agencies, and Centers for Independent Living

1. As established in APL 17-013: [Link](#)
2. As established in [42 CFR § 438.208](#) and [42 CFR § 441.301](#)

For more details, see [ECM Policy Guide](#) (May 2022).

# ECM: Adults Living in the Community Who Are At Risk for LTC Institutionalization

## *Interactions with Other Programs*

<b>Community-Based Adult Services (CBAS)</b>	<ul style="list-style-type: none"><li>Members in a CBAS program are eligible to receive ECM if they meet POF criteria</li></ul>
<b>In-Home Support Services (IHSS)</b>	<ul style="list-style-type: none"><li>Members receiving IHSS are eligible to receive ECM if they meet POF criteria</li></ul>
<b>1915(c) Waiver Programs</b>	<ul style="list-style-type: none"><li>Members can be enrolled in ECM <i>or</i> in a 1915(c) waiver program, but not both at the same time</li><li>If space is available in a 1915(c) waiver program, members may choose between ECM and the waiver program</li></ul>

For more details, see [ECM Policy Guide](#) (May 2022).

# ECM: Nursing Facility Residents Transitioning to the Community

## Summarized Operational Guidance

### Identification

- » To identify eligible Members, MCPs can rely on **referrals, analysis of their own data, or direct data feeds/established relationships with SNFs or other Providers.**

### Assessment and Care Plan

- » **Assessment:** MCPs must assess Members against criteria to determine who could be **successful to reside continuously in the community.**
  - » *DHCS encourages MCPs to use the California Community Transitions (CCT) assessment tool for this Population of Focus.*
- » **Care Plan:** The ECM Care Manager is responsible for identifying all resources to address all needs of the Member, including coordinating with local housing agencies/identifying the least restrictive community housing option, ongoing medical care that may be needed, and other needed community-based services.

### Provider Contracting

- » MCPs are **strongly encouraged** to contract with **CCT Lead Organizations.** These providers have existing relationships with community-based organizations, can coordinate community wrap around supports effectively, and have extensive knowledge of existing local community resources (e.g., housing wait lists).

For more details, see [ECM Policy Guide](#) (May 2022).

# ECM: Nursing Facility Residents Transitioning to the Community

## *Interactions with Other Programs*

**California  
Community  
Transitions (CCT)  
Money Follows the  
Person (MFTP)**

- Members can be enrolled in ECM *or* in CCT MFTP, but not both at the same time

# Community Supports

## Nursing Facility Transition/Diversion to Assisted Living Facilities (ALF)

**This Community Support facilitates nursing facility transition back into a home-like, community setting and/or prevents skilled nursing admissions for Members with an imminent need for nursing facility level of care.**

- » Providers of this Community Support are responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration
  - » Includes 24-hour direct care staff on-site to address unpredictable needs and ensure safety
- » Allowable expenses are those necessary to enable a person to establish a community facility residence
  - » **Can** include identifying/securing housing options and on-site services needed, coordinating a move into an ALF, and ongoing expenses for Members receiving the service in an ALF (such as ongoing companion services, therapeutic social/recreational programming, medication oversight, and assistance with ADL/IADL)
  - » **Cannot** include room and board or other living expenses
- » The organizations that MCPs contract with for this Community Support must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner
  - » Providers include (but are not limited to) case management agencies, Home Health agencies, adult residential facility (ARF)/Residential Care Facilities for the Elderly (RCFE) operators

For more details, see [Community Supports Policy Guide](#) (August 2022), [ECM & Community Supports FAQ](#) (August 2022).

# Community Supports

## Nursing Facility Transition/Diversion to ALF- *Continued*

### Eligibility Criteria

For **Nursing Facility Transition**, eligible individuals:

- Have resided 60+ days in a nursing facility;
- Are willing to live in an assisted living setting as an alternative to a Nursing Facility; and
- Are able to reside safely in an assisted living facility (ALF) with appropriate and cost-effective supports.

For **Nursing Facility Diversion**, eligible individuals:

- Are interested in remaining in the community;
- Are willing and able to reside safely in an ALF with appropriate and cost-effective supports; and
- Must be currently receiving medically necessary nursing facility level of care or meet the minimum criteria to receive nursing facility level of care services and in lieu of going into a facility, are choosing to remain in the community and continue to receive medically necessary nursing facility level of care services at an ALF.

# Community Supports

## Community Transition Services/Nursing Facility Transition to a Home

This Community Support covers non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for their own living expenses.

- » Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and are payable up to a total lifetime maximum amount of \$7,500
  - » **Can** include: assessing housing needs, assisting in housing search, coordinating funding for environmental modifications
  - » **Cannot** include: monthly rent or mortgage expenses
- » Providers must have experience and expertise with providing these unique services and may include (but are not limited to): case management agencies, Home Health agencies, CCT/Money Follows the Person providers.

### Eligibility Criteria

Eligible individuals:

- Are currently receiving medically nursing facility level of care (LOC) services and, in lieu of remaining in the facility or medical respite setting, are choosing to transition home and continue to receive medically necessary nursing facility LOC;
- Have lived 60+ days in a nursing home and/or Medical Respite setting;
- Are interested in moving back to the community; and
- Are able to reside safely in the community with appropriate and cost-effective supports/services.